CLINICAL LABORATORY SERVICES PAYMENT SYSTEM

*payment***basics**

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Medicare is the largest single purchaser of clinical laboratory services. Clinical lab services are tests on specimens taken from the human body (such as blood or urine) and used to help physicians diagnose or assess health. Under Part B, Medicare covers medically necessary laboratory services that are ordered by a physician when they are provided in a Medicare-participating lab. With a few exceptions, Medicare does not cover routine screening tests unless directed to by law. Under current law, covered screening tests (with some restrictions) include cholesterol and blood lipid tests, fecal occult blood testing, Pap smear tests, prostate-specific antigen tests, and diabetes screening tests.

Clinical lab services are furnished by labs located in hospitals and physician offices, as well as by independent labs. Services may also be furnished by labs located in dialysis facilities, nursing facilities, and other institutions, but frequently these services are paid under other Medicare payment systems.

Medicare spending for lab services grew by an average of 8 percent per year between 1998 and 2006, despite the fact that payment rates were updated only once during those years. Overall lab spending declined by 0.5 percent between 2006 and 2007 due to a drop in hospital-based lab spending, and increased by 4.4 percent between 2007 and 2008. In 2008, Medicare payments for clinical lab services totaled $7.1 billion.

To pay for lab services, Medicare uses 56 carrier-specific fee schedules established in 1985. Payment rates for each test were set separately in each carrier's geographic market, based on what local labs charged at the time; since 1985, the rates have been updated periodically for inflation. In addition, there are national payment limits that cap the fee schedule rates for each test. In practice, most lab claims are paid at the national payment limits.

Defining the product Medicare buys

Medicare sets payment rates for more than 1,100 Healthcare Common Procedure Coding System (HCPCS) codes used in billing for laboratory services. Although in theory there is a separate code for each service, in practice a single HCPCS code may identify more than one testing method for a given substance or more than one substance analyzed by a single method. Panel tests, which are tests commonly ordered together, have their own HCPCS codes as well.

Setting the payment rates

The fee schedule payment rates are the total payment laboratories will receive for their services; there is no beneficiary cost sharing. Because each carrier established its own fee schedule based upon charges from the laboratories in its region, fee schedule amounts may differ by region.

Beginning in 1986, the Congress established upper limits on laboratory payment rates, called national limitation amounts (NLAs). NLAs are based on the median of all carrier rates for each test. The NLAs for older tests have been repeatedly reduced and currently are set at 74 percent of the median of all carrier fee schedule amounts for each service. The NLAs for newer tests (introduced on or after January 1, 2001) are set at 100 percent of the median of the carrier rates. The payment for each service is the lesser of the providers' charge, the carrier's fee schedule amount, or the NLA (Figure 1). Because so many of the carrier payment rates are constrained by the NLAs, most lab services are paid the same national rate.

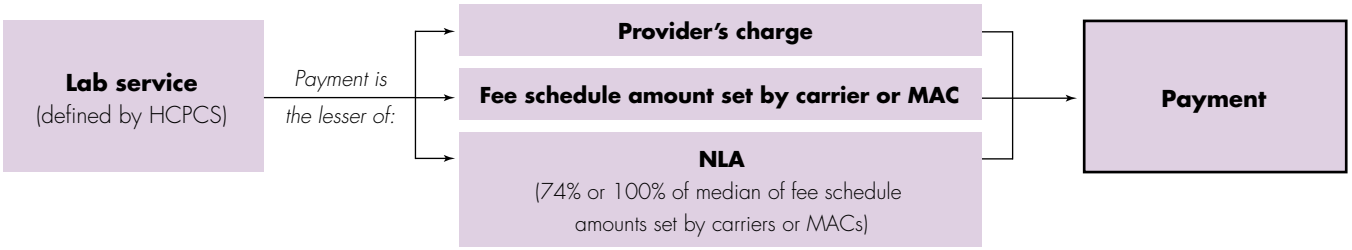
Initially, lab payments were adjusted for inflation annually using the consumer price index for all urban consumers (CPI–U), but since 1987 the Congress has specified lower update factors or none at all. Since

This document does not reflect proposed legislation or regulatory actions.

MEDPAC

601 New Jersey Ave., NW
Suite 9000
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Figure 1 Clinical laboratory services payment system



Note: HCPCS (Healthcare Common Procedure Coding System), MAC (Medicare administrative contractor), NLA (national limitation amount). The vast majority of claims are paid at the NLA. Carriers and MACs are CMS contractors who are responsible for reviewing and paying providers' Medicare claims.

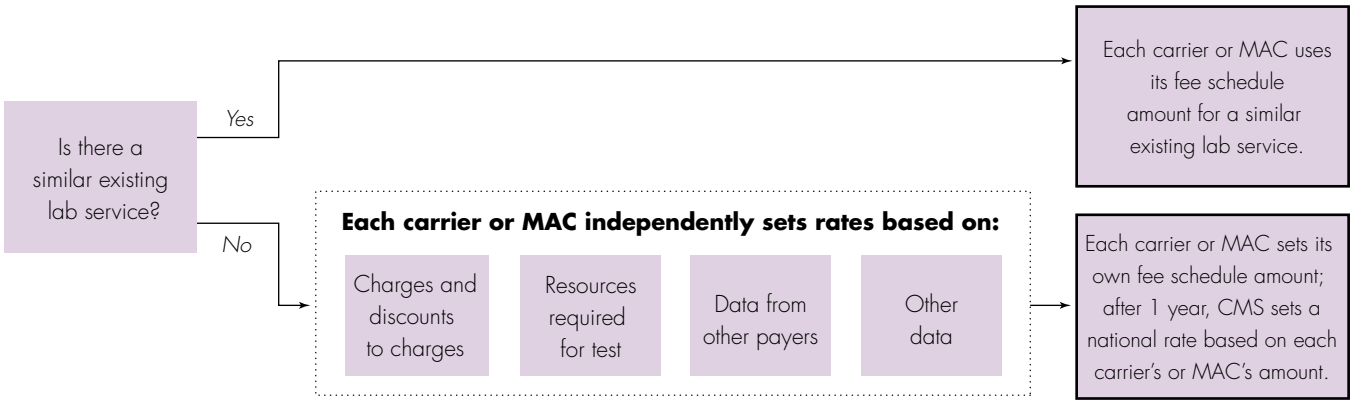
1997, payments have been updated only twice, in 2003 (by 1.1 percent) and 2009 (by 4.5 percent). From 2010 through 2013, payments will be updated annually by the CPI–U minus 0.5 percentage points.

When labs begin using newly developed tests, the Centers for Medicare & Medicaid Services (CMS) uses a "crosswalking" method to assign payment rates based on their similarity to existing tests (Figure 2). For break-through technologies for which there are no similar existing tests, CMS relies on a "gapfilling" method in which the carriers or Medicare administrative contractors (MACs) independently set rates for the first year of use.[1] Each carrier or MAC researches and sets its own payment amount based on charges for the test and routine discounts to charges, resources required to perform the test, data from other payers, and other information. After one year, CMS sets the national rate at the median of the carrier or MAC rates. CMS uses the crosswalking method more frequently than the gapfilling method to set rates for new lab tests. After one year, CMS may reconsider both the payment method (crosswalking or gapfilling) and payment amount for a new test. There is no mechanism for reviewing payment rates for existing tests.

Unlike other providers of outpatient clinical laboratory tests, critical access hospitals are paid for laboratory tests on a reasonable cost basis, instead of by the fee schedule. ■

1 CMS is in the process of transitioning from 56 carrier localities to 15 MAC jurisdictions. MACs will continue to administer the carrier fee schedules.

Figure 2 Setting fee schedule amounts for a new clinical lab service



Note: MAC (Medicare administrative contractor). Carriers and MACs are CMS contractors who are responsible for reviewing and paying providers' Medicare claims.